BPAS
British Pregnancy Advisory Service

Safeguarding Annual Report 2025/26

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Foreword

I am pleased to introduce the BPAS Safeguarding Annual Report for 2025/2026.

Heidi Stewart
Chief Executive Officer

Safeguarding is fundamental to who we are as an organisation. It underpins our commitment to delivering safe, compassionate, and patient-centred care. This report highlights the critical role our teams play in recognising, responding to, and managing safeguarding concerns across every part of BPAS.

Throughout 2025/2026, we supported over 132,000 patients, completing more than 15,500 safeguarding risk assessments and making over 9,000 safeguarding referrals. These figures reflect not only the scale of our work, but also the strength of our safeguarding culture.

I am particularly proud of the progress made this year in strengthening our safeguarding capability. The introduction of our enhanced Level 3 training programme, expansion of specialist safeguarding support, and continued investment in governance, supervision, and audit have all contributed to improving consistency, confidence, and quality across our services. The increased identification of safeguarding concerns, particularly within our Booking and Information Centre, demonstrates that our staff are recognising need at the earliest possible opportunity.

Safeguarding is never the responsibility of one team alone. The achievements outlined in this report reflect the collective efforts of both clinical and non-clinical colleagues across BPAS, working collaboratively with external partners to deliver coordinated care. I would like to thank all our staff for their ongoing professionalism, compassion, and unwavering commitment to patient safety.

While this report provides strong assurance that our safeguarding arrangements are effective and embedded, we recognise that there is no room for complacency. Our priorities for the year ahead will focus on strengthening supervision, advancing trauma-informed practice, improving documentation and assurance, and continuing to build a resilient, highly skilled workforce.

Above all, this report reaffirms our commitment to ensuring that every patient who uses our services is supported safely, respectfully, and with dignity. Safeguarding will remain at the heart of everything we do.

Executive Summary

BPAS
British Pregnancy Advisory Service
Safeguarding

Promoting and advocating for patient safety and choice, free from coercion and fear.

Safeguarding remains central to the delivery of safe, compassionate, and person-centred abortion care at BPAS. Throughout 2025-26, the organisation continued to strengthen safeguarding governance, workforce capability, quality assurance processes, and multi-agency partnerships to support the identification, assessment, and management of safeguarding concerns across all services.

During the reporting period, BPAS provided care to 132,956 patients and completed 15,530 safeguarding risk assessments, resulting in 9,163 safeguarding referrals. Adult safeguarding concerns continued to increase in complexity, while safeguarding oversight for children and young people remained robust across all care pathways.

Significant developments during the year included the launch of a new two-day Level 3 Safeguarding Training programme, achieving 80% compliance within ten months, expansion of specialist safeguarding support within the Booking and Information Centre (BIC), and continued strengthening of safeguarding governance, supervision, audit, and multidisciplinary oversight processes.

Safeguarding disclosures identified within BIC increased by 21% despite reduced overall contact volumes, providing improvements in safeguarding practice, while incident reporting supported ongoing organisational learning and service improvement.

Key priorities for 2026-27 include implementation of the revised Safeguarding Risk Assessment (SGRA), strengthening safeguarding supervision within Telemedicine services, achieving and sustaining Level 3 safeguarding compliance above 85%, further development of trauma-informed and domestic abuse practice, and implementation of the revised patient journey audit framework.

Overall, this report provides assurance that safeguarding arrangements across BPAS remain effective, embedded, and responsive to patient need, supported by strong governance, specialist expertise, workforce development, and collaborative multi-agency working.

Safeguarding at a Glance 2025-26

Executive dashboard showing demand, risk identification, escalation, learning, assurance and workforce capability.

The dashboard tells the safeguarding story through ten assurance measures: demand, risk identification, escalation, complexity, workforce capability, governance and learning.

Introduction

I am pleased to share the Safeguarding Annual Report for 2025-26. Safeguarding remains central to the delivery of safe, high-quality abortion care, and over the past year we have continued to strengthen our systems, processes, and professional practice to support patients with vigilance, compassion, and respect.

Our safeguarding framework is supported by robust governance, clear policies, and continuous improvement. Through effective risk identification, escalation and multi-agency working, we aim to respond proportionately to safeguarding concerns while maintaining patient-centred, trauma-informed care.

This report summarises safeguarding activity, audit findings, learning, training compliance, and key areas for development, demonstrating our continued commitment to patient safety and high-quality safeguarding practice.

Heidi Robinson RM, BSc

Head of Safeguarding

Safeguarding within abortion care is uniquely complex and remains a critical component of delivering safe, compassionate, and person-centred healthcare. Abortion services often provide a vital point of contact for individuals experiencing vulnerability, including domestic abuse, sexual violence, coercion, exploitation, mental health, homelessness, poverty, and barriers to accessing healthcare. For many patients, this may be the only engagement with healthcare services during a period of significant risk.

The national context continues to demonstrate increasing complexity within reproductive healthcare. In 2023, 277,970 abortions were recorded in England and Wales - the highest number since the Abortion Act was introduced and an 11% increase compared with the previous year. The age-standardised abortion rate also reached its highest level on record, reflecting increasing demand and complexity within abortion care services. At the same time, domestic abuse remains a significant public health issue, affecting more than one in five adults in England and Wales, with evidence demonstrating that abuse frequently begins or escalates during pregnancy.

Within this context, safeguarding in abortion care requires a highly skilled, trauma-informed, and professionally curious workforce capable of recognising both overt and hidden vulnerability. The continued evolution of telemedical abortion services has improved access to timely care and reduced barriers for many patients; however, it has also required ongoing adaptation in safeguarding practice to ensure robust risk assessment, effective escalation, and safe multi-agency working within remote pathways.

Throughout 2025-26, BPAS has continued to strengthen safeguarding governance, professional oversight, and organisational learning to ensure safeguarding remains embedded across all areas of service delivery. This report outlines safeguarding activity, audit findings, incident learning, training compliance, and areas for development across the organisation over the past year.

The data within this report demonstrates both the scale and complexity of safeguarding within abortion care. It reflects a strong organisational culture of vigilance, escalation, and continuous improvement, while recognising that safeguarding practice must continually evolve in response to emerging risks, societal change, and the needs of patients accessing care. Above all, this report reinforces BPAS' commitment to ensuring that every patient accessing our services is treated safely, respectfully, and with compassion, with safeguarding remaining central to the delivery of high-quality abortion care.

Patient Story

We begin this years safeguarding report with a patient story.

Making a Difference Through Teamwork

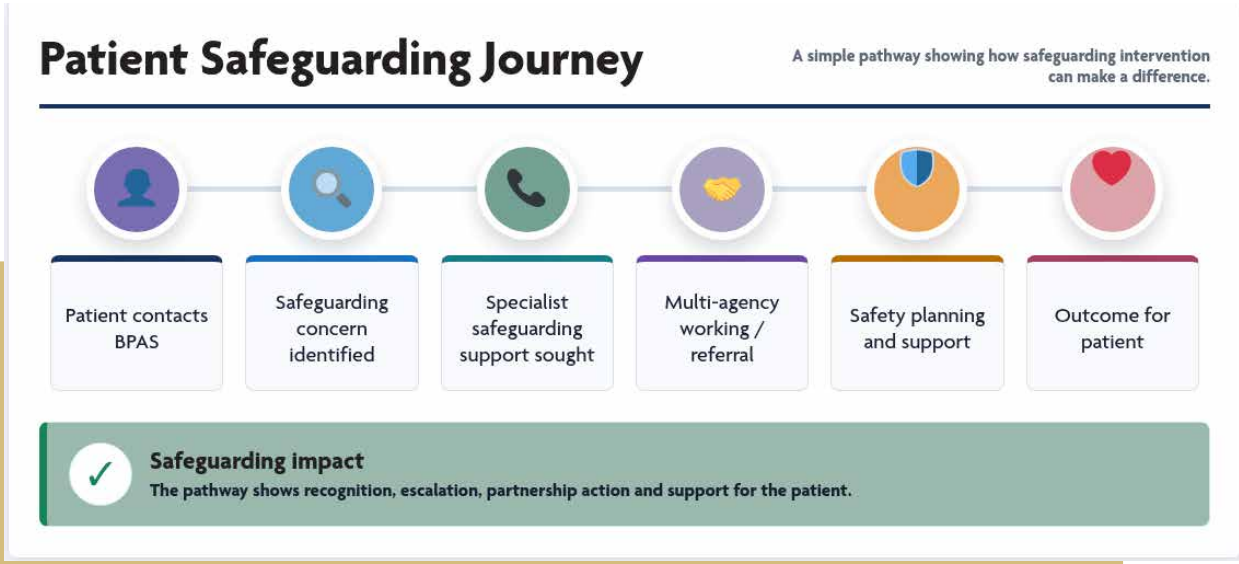
At 11:35am, the Booking and Information Centre (BIC) received a call from an NHS midwife regarding a 16-year-old patient. The young person had sadly been raped by her ex-partner and this pregnancy was as a result. An NHS scan performed that day confirmed a gestation of 23+6 weeks, and she was requesting abortion care.

Recognising the urgency of the situation, BIC immediately escalated the case to AB and to the BIC Safeguarding Team, who in turn sought support from the National Safeguarding Team. With time being critical, colleagues across multiple services worked together to ensure that the patient could access care without delay.

Having reviewed the circumstances, Richmond Clinic agreed despite already having a full list to see the patient that same day to commence treatment. The patient and her mother were approximately 2 hours away and were advised to travel as soon as possible and would be seen when they could get there. To minimise delays and reduce the burden on the patient, the case was also referred to the Telemed Safeguarding Support Nurse Midwife Practitioner (SSNMP) team, who completed as much of the consultation process as was safely and appropriately possible while she was travelling. Whilst the safeguarding team completed liaison with the police and social care in the background.

This case demonstrates the impact of effective collaboration, rapid decision-making and patient-centred care. Teams across BIC, AB, SSNMP Richmond Clinic and the safeguarding team worked seamlessly together, ensuring that a vulnerable young person was able to access the care she needed at a critical point in her life.

Whilst no service could undo the trauma that this young person had experienced, the collective efforts of those involved helped ensure that she retained choice and control over her future. The gratitude expressed by both the patient and her mother was immense, and their feedback serves as a powerful reminder of the difference that compassionate, coordinated care can make when patients need us most.



Governance and accountability

The Safeguarding Structure

BPAS has a national safeguarding team with extensive expertise and experience, providing specialist guidance, leadership, and assurance across the organisation.

The service is led by the Head of Safeguarding, who acts as the named lead for key safeguarding areas including child sexual exploitation, Prevent, domestic abuse, and female genital mutilation. The team is further supported by a Named Safeguarding Doctor, who provides expert oversight in relation to the Mental Capacity Act and complex clinical safeguarding matters.

The safeguarding team comprises seven regional Safeguarding Specialist Midwives/Nurses and two Booking and Information Centre (BIC) Safeguarding Advisors, bringing a broad range of experience across adult, child, and social care safeguarding practice. This diverse expertise supports a responsive, patient-centred approach to safeguarding across all BPAS services.

In response to the sustained volume and complexity of safeguarding concerns identified at first point of contact within BIC, an additional BIC Safeguarding Advisor post was recruited during 2025-26 to strengthen safeguarding oversight, support timely risk assessment and escalation, and enhance safeguarding support available to frontline teams.

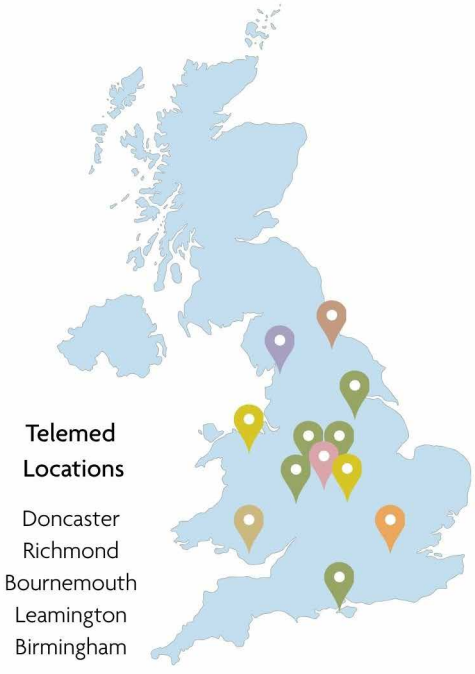
Maintaining team stability and resilience has been a key priority throughout 2025-26 and remains a continued focus for 2026-27. Particular thanks are extended to Kayleigh Gould and Amanda Palmer for the additional support they provided during periods of unexpected absence, helping to ensure continuity of safeguarding leadership and support for both staff and patients.

Safeguarding assurance is delivered through a structured regional framework covering the North East, North West, Midlands, South West, London and South East, Telemedicine, and Remote Services. Each regional Safeguarding Specialist Midwife/Nurse acts as the primary safeguarding lead within their area, reporting into the Head of Safeguarding and contributing to the quarterly Safeguarding Group.

The Head of Safeguarding reports directly to the Chief Nurse and Midwifery Officer, who acts as the Executive Lead for Safeguarding. Escalations from the quarterly Safeguarding Group can be progressed through the Quality and Risk Group, ensuring safeguarding concerns and risks are escalated appropriately to board level. This governance structure provides clear accountability, robust oversight, and organisational assurance that safeguarding remains central to the delivery of safe, high-quality care.

Key to map:

Remote Services - Carla Fletcher
Telemedicine - Valencia Anderson
South West - Alice Fairman
North West - Louise Citchley
London South East - Kayleigh Gould
Midlands - Rosie Korn
North East - Chloe Embling



National Safeguarding Team

Sophie Boyd
Named Doctor for Safeguarding

Heidi Robinson
Head of Safeguarding

Alice Fairman
Safeguarding Specialist
Midwife South West

Chloe Embling
Safeguarding Specialist
Nurse North East

Valencia Anderson
Safeguarding Specialist
Midwife Telemedicine

Kayleigh Gould
Safeguarding Specialist
Midwife South East

Louise Critchley
Safeguarding Specialist
Midwife North West

Rosie Korn
Safeguarding Specialist
Midwife Midlands

Carla Fletcher
Safeguarding Specialist
Midwife Support Services

Amanda Shurvinton
BIC Safeguarding Advisor

Sophie White
BIC Safeguarding Advisor

Risk Management and Escalation

The Daily Safeguarding Support Service

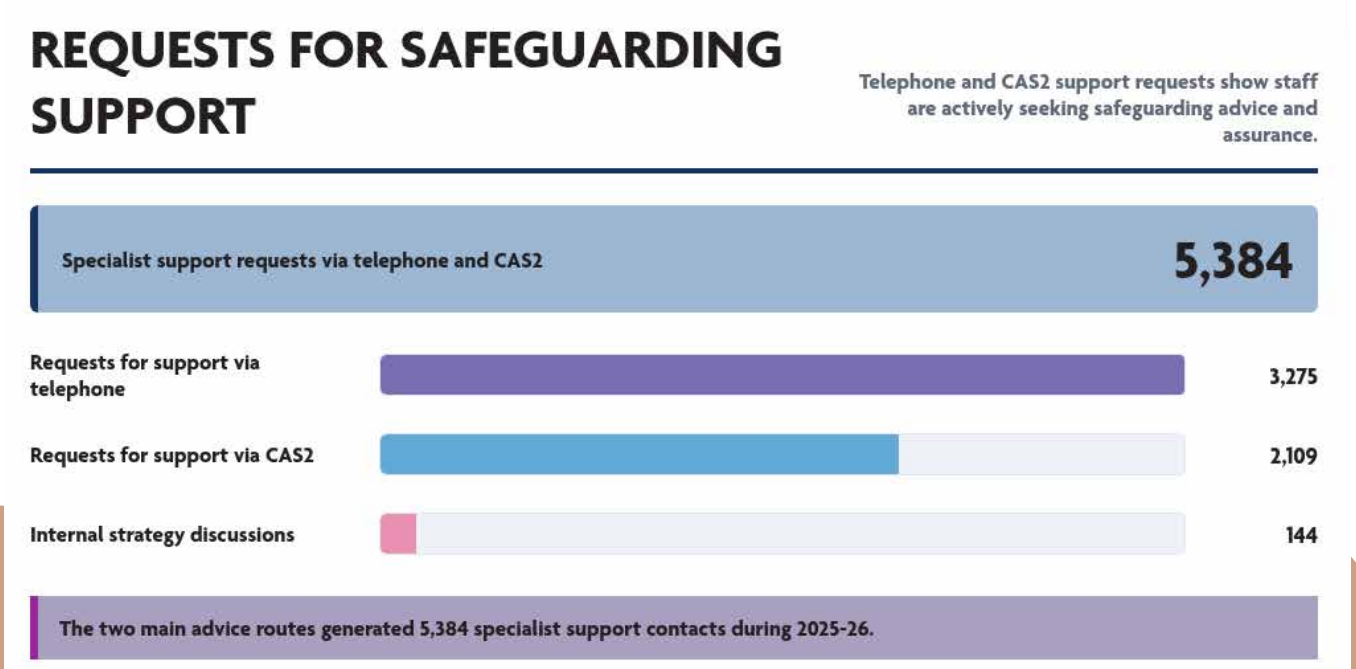
The National Safeguarding Team continues to provide a responsive and accessible on-call safeguarding support service to all BPAS staff. The DSS service is managed by two safeguarding specialist midwives/nurses per day, providing expert advice and guidance through the duty safeguarding support line. Support is available through electronic safeguarding requests within the patient electronic medical record, direct contact via the duty safeguarding support line, and the central safeguarding inbox, ensuring timely access to specialist advice across all services.

Since the launch of the duty safeguarding support phone line in June 2024, calls have increased by 765 compared with the previous financial year. This significant increase demonstrates both the value of immediate safeguarding support and the growing confidence of staff in seeking case-by-case guidance for complex or high-risk situations.

The volume of safeguarding support requests reflects strong staff engagement with safeguarding escalation pathways and reinforces the importance of specialist safeguarding oversight within abortion care. The consistently high use of telephone support particularly highlights the need for accessible, real-time safeguarding advice to support frontline staff managing complex, urgent, and emotionally demanding presentations.

This service continues to play a critical role in strengthening professional curiosity, supporting safe decision-making, and promoting consistent safeguarding practice across the organisation.

Action:
360 feedback for DSS support service to identify areas of improvement and development



Use of Professional Challenge

Throughout 2025-26, continued emphasis was placed on fostering a culture where staff feel supported to question, challenge, and escalate concerns appropriately. Professional curiosity and constructive challenge remain central to effective safeguarding practice, supporting reflective decision making, patient safety, and continuous learning.

Complex safeguarding concerns were managed through established escalation pathways, including daily safeguarding huddles, specialist advice via the Duty Safeguarding Support (DSS) service, and multidisciplinary discussions where required. These processes supported collaborative risk assessment, safety planning, continuity of oversight, and timely access to safeguarding expertise.

Use of the Child Protection Information Sharing system (CP-IS) continued to support identification of additional vulnerabilities and inform safeguarding assessments and care planning. Where required, external multi-agency discussions were convened to facilitate coordinated information sharing, risk management, and safeguarding responses for patients with complex or high-risk presentations.

Exception Reports

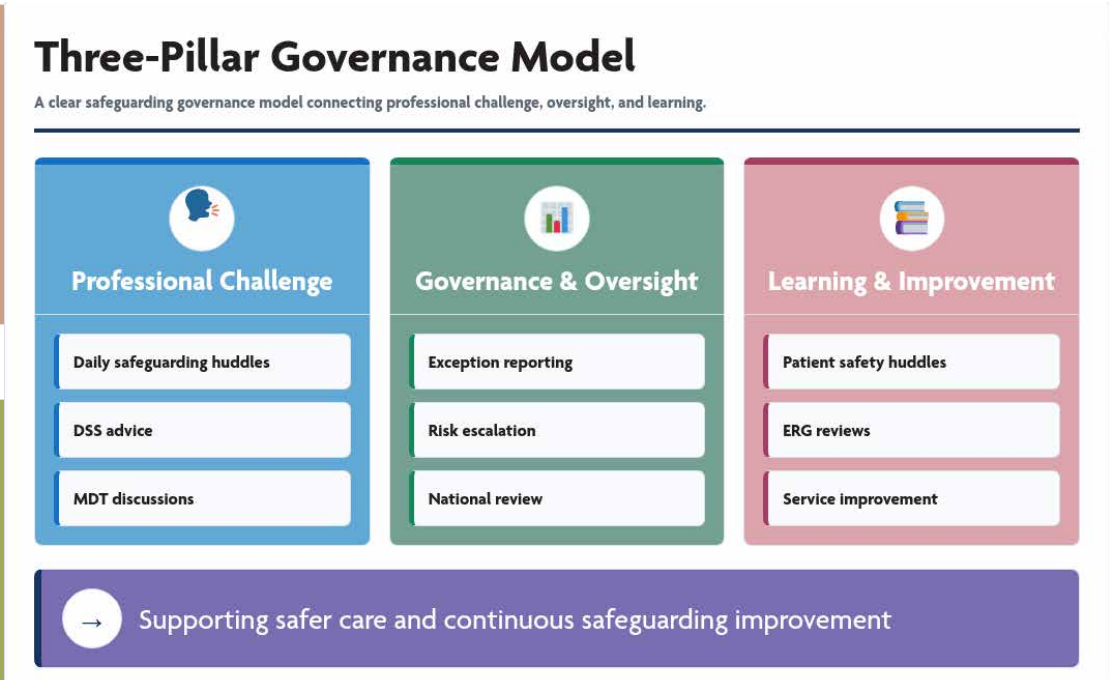
Quarterly exception reporting remained a key component of the safeguarding governance framework during 2025-26. Regional Safeguarding Specialist Nurses and Midwives submitted reports highlighting safeguarding activity, emerging risks, workforce pressures, training and supervision compliance, complex case management, and examples of good practice.

Review of exception reports at national level supported shared oversight, early identification of risks, escalation where required, and informed wider safeguarding priorities, workforce planning, and quality improvement activity.

Patient Safety Huddles

Safeguarding staff continued to attend regional patient safety huddles, supporting multidisciplinary review of incidents, good practice, and learning themes across services. These discussions facilitated reflective learning, identification of safeguarding considerations, and opportunities to strengthen patient-centred care.

Where significant safeguarding concerns or incidents were identified, cases were escalated through organisational Event Response Group (ERG) processes to ensure appropriate review, governance oversight, and embedding of learning across the organisation.



Booking and Information Centre (BIC) Safeguarding Developments

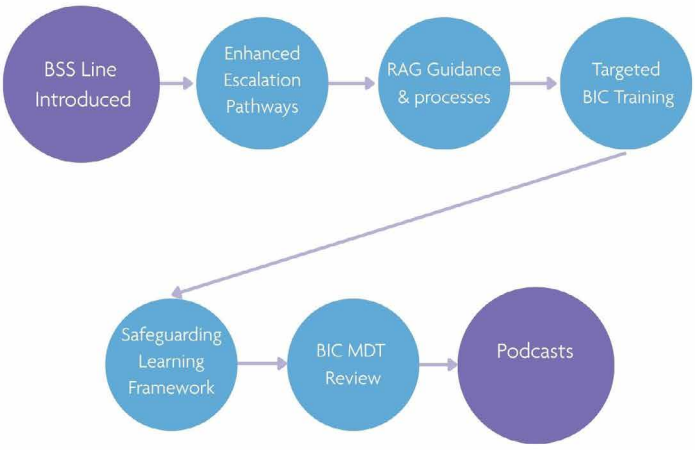
Throughout 2025-26, significant work was undertaken to strengthen safeguarding oversight, escalation processes, and safeguarding support within the Booking and Information Centre (BIC), led by Carla Fletcher, Safeguarding Specialist Midwife for Support Services, with implementation support from Amanda Shurvinton. This included the introduction of enhanced safeguarding escalation pathways, targeted workforce training, multidisciplinary oversight processes, and strengthened safeguarding governance arrangements.

A dedicated BIC Safeguarding Support (BSS) phone line was introduced to provide real-time safeguarding advice and escalation support for frontline advisers managing complex or high-risk concerns. Alongside this, revised safeguarding escalation processes and RAG rating guidance were implemented, supported by safeguarding-specific training for advisers, Team Managers, Quality Coaches, and administrators. These developments strengthened consistency in safeguarding decision making and ensured timely review and escalation of concerns according to identified risk.

Following a review of safeguarding activity and oversight processes, routine safeguarding team review of Green-rated cases was removed where concerns had been appropriately identified and documented for onward clinical review. This reduced safeguarding administrative workload by approximately 25%, enabling greater focus on coaching, audit activity, reflective learning, and quality improvement initiatives within BIC.

Further developments included BIC-specific safeguarding training to strengthen staff confidence in identifying, documenting, escalating, and managing safeguarding concerns within telephone-based interactions, alongside the introduction of a structured Safeguarding Omissions and Learning Opportunities process to support reflective practice and learning. The establishment of the BIC MDT Review Group also enhanced multidisciplinary oversight of clinical, operational, risk, and safeguarding processes, ensuring safeguarding considerations remained embedded within service development and change.

Additional improvements included the relaunch of safeguarding guidance documentation and the introduction of safeguarding podcasts, providing staff with accessible learning resources to support professional curiosity, recognition of safeguarding risk factors, and confidence in responding to safeguarding concerns at first point of contact.



Safeguarding and Activity Trends

Overall Safeguarding Activity

During 2025-26, safeguarding activity remained consistently high across the organisation, reflecting the complexity and vulnerability of patients accessing care and the continued embedding of safeguarding practice within operational pathways.

BPAS provided care to 132,956 patients, including 3,513 patients under 18 years old, representing approximately 3% of the overall patient cohort.

A total of 15,530 safeguarding risk assessments (RAs) were completed across adult and child safeguarding pathways, demonstrating continued vigilance and routine safeguarding consideration within abortion care provision.

Overall, 9,163 safeguarding referrals were made during the reporting period, equating to approximately 6.9% of all patients seen by BPAS.

The data demonstrates a strong safeguarding focus across all services, with safeguarding risk assessments completed for over 12% of all patients accessing care.

All patients under 18 accessing care received a safeguarding risk assessment, reflecting robust compliance with safeguarding expectations for children and young people. Adult safeguarding assessments also remained significant, demonstrating continued recognition of vulnerabilities including domestic abuse, coercion, exploitation, mental health concerns, and wider social risk factors.

Safeguarding incidents remained low in proportion to overall patient activity, suggesting effective identification and management of safeguarding concerns within routine care pathways.

Incident reporting continues to support organisational learning, governance oversight, and service improvement activity.

Safeguarding Risk Assessments 2025-26

Adult safeguarding risk assessments account for around three quarters of all RAs.

Adult vs Child Safeguarding Trends

Adult Safeguarding

Adult safeguarding concerns represented the majority of safeguarding activity throughout 2025-26. Across the year 11,841 adult safeguarding RAs were completed, accounting for approximately 76% of all safeguarding RAs.

Adult safeguarding activity remained consistently high across all four quarters, with the highest adult safeguarding activity recorded during Q2.

The data demonstrates increasing recognition of adult safeguarding vulnerabilities, particularly within domestic abuse, coercion and controlling behaviour, and mental health vulnerability,

The increase in adult safeguarding activity compared with previous reporting periods suggests greater professional curiosity, improved identification of hidden harm, increased confidence in recognising non-physical safeguarding indicators, and strengthening safeguarding culture within frontline services.

Adult safeguarding concerns also demonstrated increased complexity, with many cases requiring multidisciplinary discussion, external information sharing, safety planning, and ongoing safeguarding oversight rather than immediate single-agency intervention alone.

Child and Young Person Safeguarding

During 2025-26, a total of 3,513 patients under the age of 18 accessed services, representing approximately 3% of the overall patient population. Safeguarding oversight for children and young people remained a significant focus throughout the reporting period, with enhanced safeguarding assessment routinely embedded within all under 18 care pathways.

The most commonly identified safeguarding theme remained “no concerns identified aside from under 18 status,” reflecting the consistent safeguarding oversight and risk assessment applied to younger patients accessing care. However, recurring themes continued to include limited support networks, third-party booking activity, mental health concerns, learning disabilities and additional vulnerabilities, late gestation presentations, domestic abuse, sexual abuse or assault indicators, and concerns relating to exploitation.

Despite the complexity of presentations, the data demonstrates increasing proportionality and consistency within safeguarding escalation processes for under 18 patients. Improved differentiation between expected safeguarding oversight and concerns requiring active escalation or intervention suggests increasing staff confidence, strengthened professional curiosity, and more consistent safeguarding decision making across services.

This is likely supported through the significant safeguarding training and workforce development activity completed during 2025-26, including the introduction of enhanced safeguarding training packages, increased safeguarding visibility within operational processes, strengthened safeguarding guidance, and continued access to specialist safeguarding advice and support. Collectively, these developments continue to strengthen the organisation’s ability to identify, assess, and respond appropriately to safeguarding concerns affecting children and young people accessing care.

Key Safeguarding Incident Themes 2025-26

Most safeguarding incidents related to process, documentation and multi-agency follow-up rather than direct patient harm.

GROUPED INCIDENT THEMES AS PERCENTAGE OF IDENTIFIED THEMES

89% of identified incident themes related to process, documentation, escalation or multi-agency follow-up.

337

Process, documentation and follow-up themes

Includes escalation/action, record-keeping, compliance and multi-agency follow-up.

27

Direct patient incident theme

Safeguarding incident against patient whilst in contact with BPAS.

14

Notification / review themes

External safeguarding review and pregnant under 13 notification themes.

Increasing Demand for Specialist Safeguarding Support

Demand for specialist safeguarding support remained high throughout the year. Across 2025-26:

- 2,109 requests for corporate safeguarding support were received via CAS2
- 3,275 telephone requests for safeguarding advice and support were received

This demonstrates significant reliance on specialist safeguarding expertise to support complex decision making, escalation processes, risk assessment, and real-time safeguarding advice.

The consistently high use of safeguarding support pathways provides assurance that staff continue to appropriately seek guidance and escalation support where concerns arise.

Multidisciplinary Oversight and Strategy Discussions

A total of:

- 144 internal strategy discussionswere recorded during the reporting period.

This reflects:

- increasing multidisciplinary oversight
- collaborative safeguarding management
- use of reflective discussion to support complex case management and safe care planning.

The increase in strategy discussions during later quarters may also indicate:

- strengthening safeguarding governance processes
- improved escalation culture
- greater recognition of the value of collaborative safeguarding review.

Safeguarding Data Comparison: 2024-25 vs 2025-26

Overall Patient Activity

Overall patient contacts increased from 126,647 in 2024-25 to 132,956 in 2025-26, representing an increase of approximately 5%.

Despite increased activity levels the proportion of under 18 patients remained stable at approximately 3%, while adult patients continued to account for approximately 97% of activity.

This demonstrates continued growth in service demand whilst maintaining consistent demographic patterns.

Safeguarding Risk Assessments (RAs)

Overall safeguarding RAs reduced from 17,598 in 2024-25 to 15,530 in 2025-26. This represents a reduction of approximately 12% year-on-year.

The percentage of patients requiring safeguarding RAs also reduced from 14.1% in 2024-25 to 12.3% in 2025-26.

This reduction occurred despite increased patient activity levels and reflects improved confidence and accuracy in triage processes, increased staff understanding of thresholds for safeguarding escalation, strengthened early identification pathways, and greater consistency in safeguarding documentation and decision making.

Safeguarding Trends

Adult safeguarding concerns increased significantly during 2025-26, suggesting improved identification.

This reflects increasing professional curiosity and confidence in identifying adult safeguarding risk factors that may historically have been under-recognised.

Under 18 safeguarding RAs reduced substantially compared with the previous reporting year.

However, this reduction is likely reflective of more proportionate safeguarding escalation, improved differentiation between routine safeguarding oversight and active safeguarding concerns, and clearer safeguarding guidance for younger patients.

Enhanced safeguarding assessment remained embedded across all under 18 pathways despite reduced formal RA numbers.

Quarterly Trends

2024–25

- Safeguarding activity was highest in Q1 and Q3.
- RA totals remained consistently above 4,200 per quarter.

2025–26

- Activity remained more stable throughout the year.
- Q2 demonstrated the highest safeguarding RA activity (4,498).
- Q4 demonstrated the highest safeguarding disclosure activity overall.

This may indicate increasing consistency in safeguarding identification and recording practices across the year.

Action:
Launch SGRA PILOT with revised tool

Partnerships and Muliti Agency Working

The data demonstrates a strong safeguarding focus across all services, with safeguarding risk assessments completed for over 12% of all patients accessing care.

Although safeguarding RAs remained high, overall safeguarding referrals were proportionately lower than total safeguarding assessments:

- 15,530 safeguarding RAs compared with
- 9,163 external safeguarding referrals

This demonstrates increasing proportionality in safeguarding escalation and suggests growing confidence in:

- risk assessment
- professional judgement
- determining when external safeguarding intervention is required.

Quarter 2 demonstrated the highest referral activity, which reflects improved safeguarding recognition, increased complexity of presentations, and operational factors impacting demand during this period.

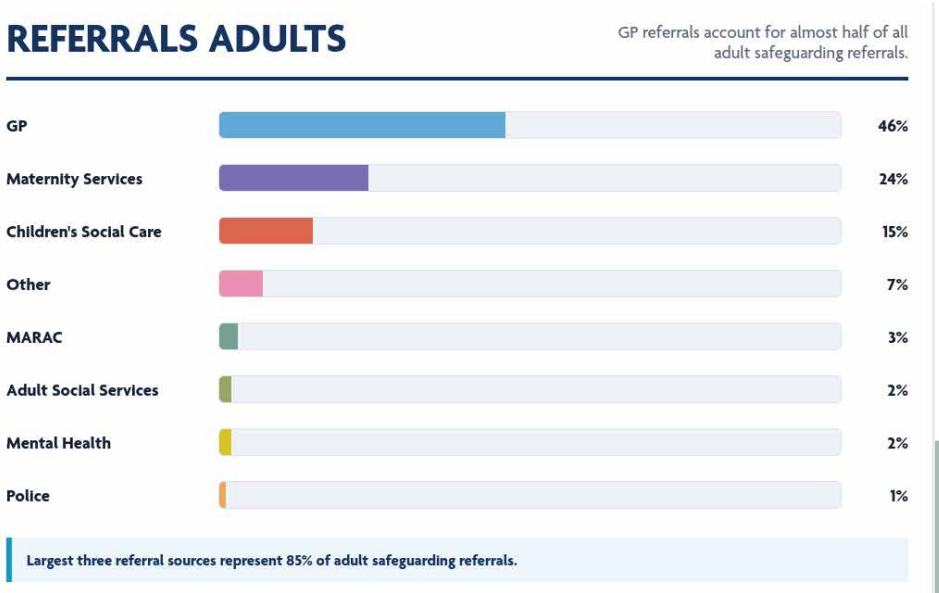
The reduction in referral rates during Q4 suggests improved early intervention and internal safeguarding management, more consistent triage processes, and increasing maturity of safeguarding decision making frameworks.

Safeguarding Referrals

Safeguarding referrals reduced from 11,002 referrals in 2024-25 to 9,163 referrals in 2025-26.

This represents a reduction of approximately 17%. The reduction in referral activity may suggest improved quality of initial safeguarding risk assessment, more proportionate information sharing and escalation, and improved differentiation between concerns requiring specialist referral versus those managed through internal safeguarding oversight and support.

Importantly, referral reductions occurred alongside continued high levels of disclosure identification, providing some assurance that concerns continue to be recognised and managed appropriately rather than missed.



Interface with statutory partners

Throughout 2025-26, the Head of Safeguarding continued to support external partnership working and safeguarding assurance through engagement with statutory and healthcare partners. This included presenting at two national GP safeguarding forums to increase understanding of BPAS patient pathways, service locations, operational processes, and safeguarding arrangements. These sessions supported relationship building, strengthened awareness of BPAS as an organisation, and aimed to improve the quality and timeliness of direct safeguarding referrals and partnership communication.

The Head of Safeguarding also contributed to two rapid reviews during the reporting period, supporting both organisational participation and the embedding of identified learning within practice and governance processes.

The national safeguarding team continued to strengthen collaborative relationships with statutory partners throughout the year, including engagement with Integrated Care Board (ICB) assurance processes, safeguarding boards, social care, and community-based support agencies. Ongoing multi-agency working remained central to supporting effective information sharing, safeguarding oversight, and coordinated patient-centred care.

Regionally, safeguarding staff also continued to strengthen local partnership networks. In the North West, Safeguarding Specialist Midwife Louise Critchley has established strong working relationships with local Independent Domestic Violence Advisors (IDVAs) and three separate domestic abuse support services, alongside regular attendance at safeguarding subgroup meetings. This has supported improved partnership communication, local safeguarding knowledge, and access to community-based support pathways for patients.

Within the London and South East region, multi-agency engagement improved during Quarter 4 following restoration of safeguarding leadership visibility across the division by Kayleigh Gould. Progress included the re-establishment of communication pathways with safeguarding partners, increased safeguarding leadership presence, and improved collaboration in the management of complex safeguarding cases.

Between January and April 2026, Chloe, Safeguarding Specialist Midwife for the North East, undertook eight clinic visits and delivered 21 safeguarding supervision sessions, either face-to-face or remotely.

Through increased safeguarding visibility, relationship building, and accessible support to clinical teams, supervision compliance improved significantly from 45.1% to 80% during Quarter 4. Whilst slightly below the organisational target of 85%, this represents substantial progress within a short timeframe.

Clinic visits focused on providing safeguarding support, promoting reflective practice, increasing engagement with supervision and training, and identifying opportunities for improvement. This work has strengthened staff confidence and contributed to embedding a positive safeguarding culture across the region.

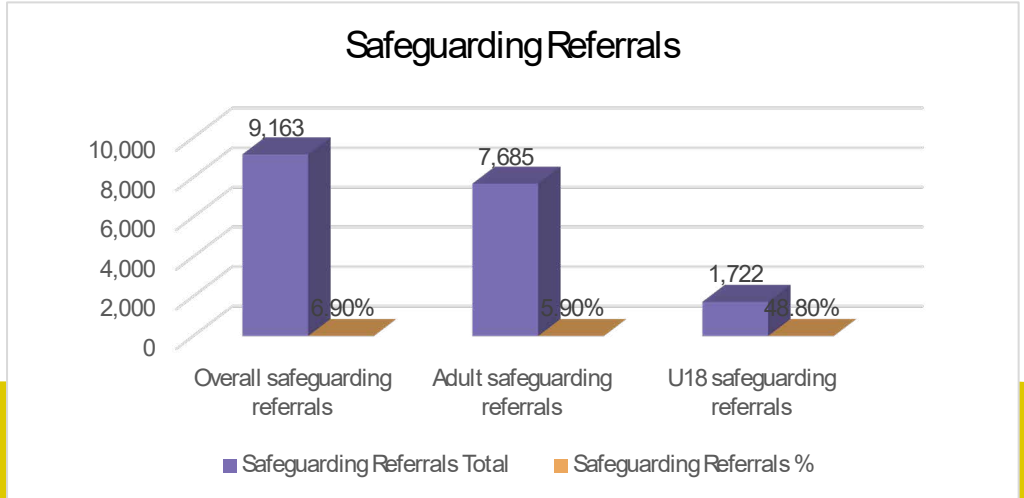


Chart: Safeguarding referrals

BIC Safeguarding Activity Analysis

BIC Activity Overview

During 2025-26, the Booking and Information Centre (BIC) continued to manage significant levels of patient contact as the organisation's primary access point for telephony and online booking requests. Across the reporting period:

- 211,260 inbound calls were answered
- 124,430 online booking requests (AR forms) were received
- Total BIC contacts reached 335,690

Activity levels remained consistently high throughout the year, with the highest total monthly contact volume recorded in July 2025 (31,363 contacts). Quarter 2 demonstrated the highest overall activity levels, with 89,929 total contacts managed.

This sustained level of activity highlights the critical role of BIC staff in the early identification of safeguarding concerns and the importance of robust safeguarding systems operating effectively at the first point of contact.

Safeguarding Disclosure Activity

A total of 14,308 safeguarding disclosures were identified within BIC during 2025-26.

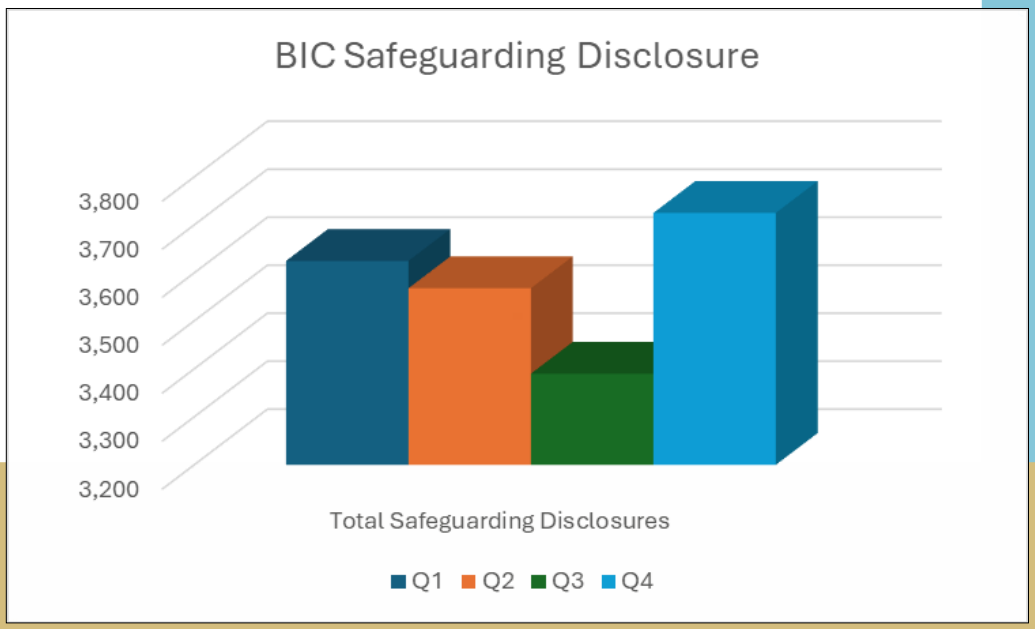
Of these:

- 8,785 (61%) related to adults
- 5,523 (39%) related to patients under 18 years

Safeguarding disclosure activity remained consistently high throughout the year, averaging approximately 1,192 disclosures per month.

The highest monthly safeguarding disclosure total was recorded in January 2026, with 1,334 disclosures identified.

Quarterly safeguarding disclosure levels remained consistent overall, demonstrating sustained identification and escalation of safeguarding concerns throughout the reporting period; with the lowest activity observed in Q3 (3,390) and the highest in Q4 (3,725).



Safeguarding Triage Activity

Safeguarding concerns identified within BIC continued to be risk assessed using the Red, Amber, Green (RAG) triage process.

Across the year:

- 31 cases were triaged as Red
- 11,143 cases were triaged as Amber
- 3,134 cases were triaged as Green

The predominance of Amber triage outcomes reflects the complexity of safeguarding concerns identified at first contact, often requiring further clinical review, information gathering, or specialist safeguarding oversight.

There was a notable increase in Green triage activity during Q3 and Q4, particularly from October 2025 onwards. This may reflect:

- increased confidence amongst BIC staff in recognising and documenting lower-level safeguarding concerns,
- improvements in safeguarding training,
- or changes in triage processes and recording practices.

The relatively low number of Red triage cases demonstrates that immediate high-risk safeguarding presentations remain uncommon, although these cases continue to require urgent specialist oversight and escalation.

Under 18 Safeguarding Themes

The most commonly identified safeguarding theme for patients under 18 remained 'no concerns apart from under 18 status' attributing 4,244 cases. This reflects the routine safeguarding assessment and enhanced oversight required for all under 18 patients accessing care.

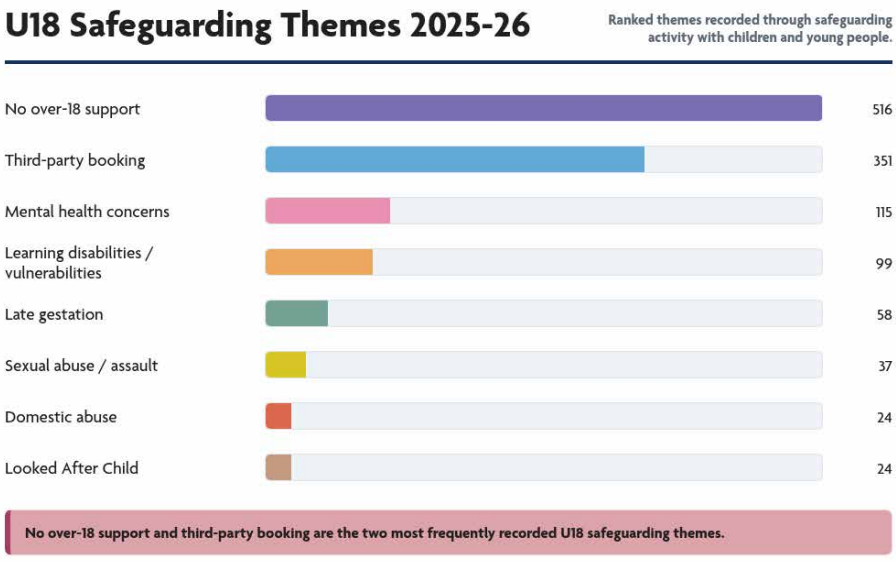
Other notable themes included:

- No over 18 support
- Third party booking
- Mental health concerns
- Learning disabilities/difficulties
- Late gestation
- Sexual abuse/assault
- Domestic abuse
- Looked after child (LAC)

The frequency of 'no over 18 support' and 'third party booking' themes continues to demonstrate the importance of robust assessment of support systems, confidentiality, autonomy, and potential coercion risks in younger patients.

Mental health vulnerabilities, learning disabilities, and indicators of exploitation or abuse also remained recurrent safeguarding themes requiring ongoing multidisciplinary oversight.

Action:
Audit impact of CP-IS checking



Key themes and emerging trends

Early Identification of Safeguarding Concerns

The data demonstrates the continued importance of BIC as a critical safeguarding gateway within the organisation. The volume of safeguarding disclosures identified reflects increasing confidence in recognising and escalating concerns at the earliest opportunity.

This is likely supported by:

- continued investment in safeguarding training and workforce development,
- improved visibility of safeguarding information within clinical systems,
- access to timely specialist safeguarding advice and support,
- and strengthened safeguarding processes within BIC to support early identification and appropriate escalation of concerns.

Increasing complexity of presentations

The predominance of Amber triage concerns demonstrates the complexity and nuance of safeguarding presentations identified at first contact. Many concerns require professional judgement, contextual risk assessment, and multidisciplinary discussion rather than immediate escalation alone.

Support needs in younger patients

The continued prevalence of themes relating to lack of adult support, third party involvement, and mental health concerns highlights the vulnerability of some under 18 patients presenting to services and reinforces the importance of robust safeguarding assessment pathways.

BIC Assurance and Risk Mitigation

The data supports continued assurance that safeguarding concerns are being routinely identified and risk assessed within BIC. The combination of safeguarding training, specialist safeguarding support, triage systems, and escalation pathways provides multiple safeguards to support early recognition and intervention.

The Booking and Information Centre (BIC) remains a key safeguarding access point within the organisation, managing over 335,000 patient contacts during 2025-26. Across the reporting period, more than 14,000 safeguarding disclosures were identified, demonstrating the continued importance of early safeguarding recognition at first contact. Disclosure activity remained consistently high throughout the year, with the majority of concerns requiring Amber level safeguarding review and oversight. Under 18 safeguarding activity continued to demonstrate themes relating to vulnerability, limited support networks, mental health concerns, and third-party involvement. Ongoing safeguarding training, specialist safeguarding support, and strengthened safeguarding systems within BIC continue to support improved recognition, escalation, and management of safeguarding concerns across the service.

BIC Comparison: 2024-25 vs 2025-26

Comparison of BIC safeguarding data across the two reporting years demonstrates continued high levels of safeguarding activity within the Booking and Information Centre (BIC), alongside evidence of strengthening safeguarding identification processes, increasing confidence in safeguarding triage, and greater proportionality in risk assessment and escalation practices.

Total BIC contacts reduced by 6.7% from the previous financial year. Despite this reduction in overall contact activity, safeguarding disclosure activity increased significantly throughout 2025-26 with a 21% increase, suggesting improved safeguarding recognition and identification at first point of contact.

This increase is particularly notable given the reduction in overall BIC contact activity and may reflect:

- improved safeguarding awareness and professional curiosity
- increased staff confidence in identifying safeguarding concerns
- strengthened safeguarding escalation pathways
- improved safeguarding training
- and enhanced safeguarding visibility within BIC systems and processes

The average number of safeguarding disclosures increased from approximately 985 disclosures per month in 2024-25, to 1,192 disclosures per month in 2025-26.

Quarterly safeguarding disclosure activity also demonstrated greater consistency across 2025-26 compared with the previous reporting period.

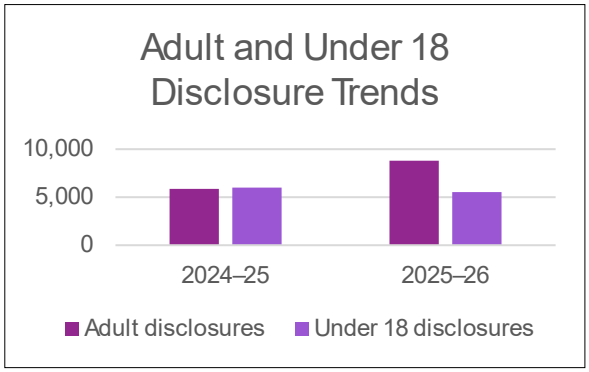
Adult and Under 18 Disclosure trends

In 2024-25 under 18 disclosure trends represented the majority of safeguarding disclosures (51%), with adult disclosures accounting for 49%. In 2025-26 adult disclosures increased significantly and represented 61% of disclosures, whilst under 18 disclosures reduced to 39%.

This shift suggests increasing recognition of adult safeguarding vulnerabilities within patient pathways, including concerns relating to domestic abuse, coercion, mental health, exploitation, vulnerability and wider psychosocial factors.

The reduction in under 18 disclosure numbers does not necessarily indicate reduced vulnerability within this patient group, but is reflective of improved proportionality of safeguarding recording, greater clarity regarding expected safeguarding oversight for under 18's, and more focused escalation of safeguarding concerns requiring active intervention.

Red-rated cases remained consistently low across both years, with 24 red cases in 2024-25 compared to 31 in 2025-26. This demonstrates that immediate high-risk safeguarding presentations remain relatively uncommon within overall BIC activity, although these cases continue to require urgent specialist safeguarding oversight and escalation and have robust pathways to ensure this.



Training and Workforce Development

The Bespoke Level 3 Safeguarding Training

In June 2025, the National Safeguarding Team developed and launched a new two-day face-to-face Level 3 Safeguarding Training programme for the organisation. The package was designed to deliver safeguarding education that was clinically relevant, reflective of the unique complexities within abortion care, and fully aligned with the requirements set out within the Intercollegiate Document.

This represented a significant enhancement to the previous safeguarding training model, which had been delivered remotely as a combined adult and child safeguarding session over a three-hour period. The revised programme provides substantially greater depth, reflective discussion, and practical application of safeguarding principles, enabling staff to engage more meaningfully with complex safeguarding themes and decision-making.

Between June 2025 and April 2026, 368 staff members completed the new training programme, achieving 80% organisational compliance within a ten-month period. This represents a significant achievement and demonstrates the organisation's continued commitment to strengthening safeguarding knowledge, confidence, and professional accountability across the workforce.

The programme was collaboratively developed by the entire safeguarding team to ensure the content remained practical, relatable, and grounded in real safeguarding presentations encountered within BPAS services. Particular thanks are extended to Alice Fairman and Louise Critchley for leading the finalisation, coordination, and implementation of the package to ensure successful delivery within challenging timescales.

The introduction of the revised Level 3 programme has strengthened organisational assurance that staff are equipped with the knowledge, professional curiosity, and practical safeguarding skills required to safely manage complex and evolving safeguarding presentations across both face-to-face and telemedical pathways.

Chart: Safeguarding Training Level 1-3

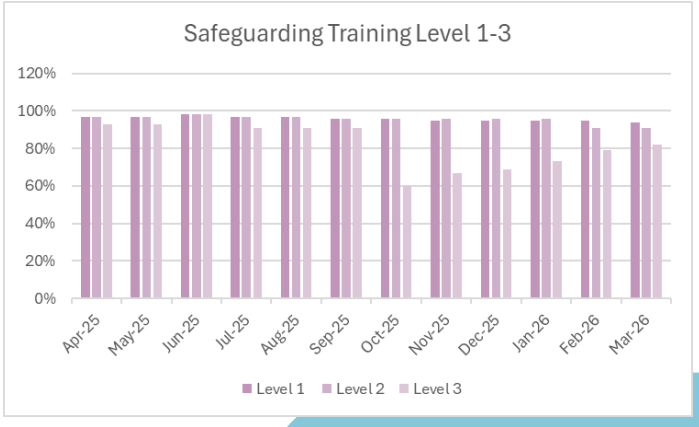
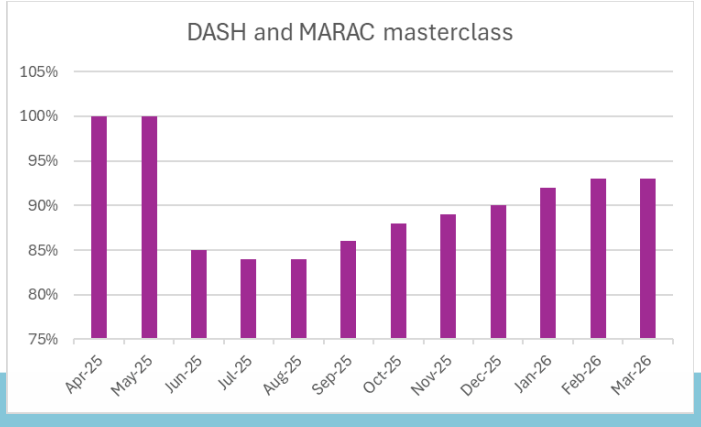


Chart: Safeguarding Training DASH



Safeguarding Capability and Continuous Learning

All other mandatory safeguarding training compliance remained consistently high throughout 2025-26. DASH training continued to be delivered to new starters and staff requiring refresher training, supporting the organisation's ability to identify, risk assess, safety plan, and respond appropriately to patients experiencing domestic abuse, stalking, harassment, and honour-based abuse.

Since its introduction in 2024, DASH training has become an established component of BPAS's safeguarding response, contributing to increased staff confidence in recognising and responding to domestic abuse and associated safeguarding risks. Compliance has remained high throughout the reporting period, with a temporary reduction observed during the implementation phase of the new Level 3 Safeguarding Training programme.

All new starters continue to receive a safeguarding induction and welcome supervision from their regional Safeguarding Specialist Nurse/Midwife, alongside mandatory safeguarding training and competency assessments. This supports safe onboarding, introduces key safeguarding processes, and ensures staff feel confident in managing the unique safeguarding complexities associated with abortion care before working independently.

A standalone Perinatal Mental Health training module was introduced during the year, further strengthening the organisation's building-block approach to safeguarding education. Additional resources and training were also implemented to support managers in responding to safeguarding concerns disclosed by staff members, including domestic abuse. This work was supported through collaboration between the Head of Safeguarding, EIDA, and Human Resources to strengthen internal support pathways and organisational responses.

Whilst safeguarding supervision compliance remains strong across most regions, accessibility within Telemedicine services continues to present challenges due to workforce size and service demand. Improving access to supervision within Telemedicine will remain a priority during 2026-27.

Looking forward, BPAS will continue to strengthen its safeguarding education programme. Kayleigh Gould and Chloe Embling will lead the development of a bespoke domestic abuse training package aligned to the Intercollegiate Document, replacing the current e-Learning for Healthcare package with training tailored to the specific safeguarding risks and patient needs encountered within abortion care. A trauma-informed training package will be produced.

In addition, a dedicated learning event focusing on honour-based abuse and forced marriage is planned for 2026-27, further supporting staff confidence in recognising and responding to these complex safeguarding concerns.

Action:
Develop internal domestic abuse training to replace eLFH Level 1 and Level 2

Action:
Develop standalone trauma-informed training package

Scenario Based Education

Quarterly safeguarding education sessions delivered across all clinics and Telemedicine teams using realistic case scenarios informed by incidents, audits, safeguarding reviews, emerging themes, and national guidance.

Sessions encourage discussion of complex safeguarding presentations, exploration of decision-making processes, professional challenge, and application of safeguarding principles. Staff are supported to consider risk, vulnerability, information sharing, consent, capacity, escalation, and multi-agency working within realistic clinical contexts.

Scenario-based discussions enable staff to translate safeguarding theory into practice, strengthening confidence in identifying concerns, undertaking risk assessments, documenting professional judgement, escalating concerns appropriately, and managing complex safeguarding presentations.

SBE has strengthened engagement with safeguarding education, promoted reflective practice, increased safeguarding visibility, and supported more consistent safeguarding decision making across services. The programme contributes to embedding safeguarding as a continuous learning process and supports the development of a proactive safeguarding culture throughout BPAS.

Scenario-based education has become an established component of BPAS's safeguarding development programme, supporting workforce confidence, reflective practice, and consistent safeguarding decision making across services.

Supervision and Reflective Practice

BPAS operates a well-established regional safeguarding supervision model, providing consistent, accessible, and relationship-based safeguarding support across all services. The model is delivered by regional Safeguarding Specialist Midwives/Nurses, enabling continuity between supervisor and supervisee and supporting the development of trusted professional relationships, reflective practice, and psychologically safe discussion.

Each regional safeguarding lead provides a combination of individual and group safeguarding supervision through both face-to-face and remote delivery methods, ensuring flexibility and accessibility for staff across geographically diverse services. This continuity model allows supervisors to develop a detailed understanding of the operational pressures, patient demographics, and safeguarding complexities within their region, strengthening the quality and relevance of supervision provided.

Safeguarding supervision is delivered as a minimum twice yearly for all practitioners, with additional ad-hoc sessions readily available in response to complex cases, emerging concerns, or practitioner wellbeing needs. Uptake and engagement with supervision remain exceptionally strong, reflecting a positive safeguarding culture and the value staff place on dedicated reflective safeguarding support.

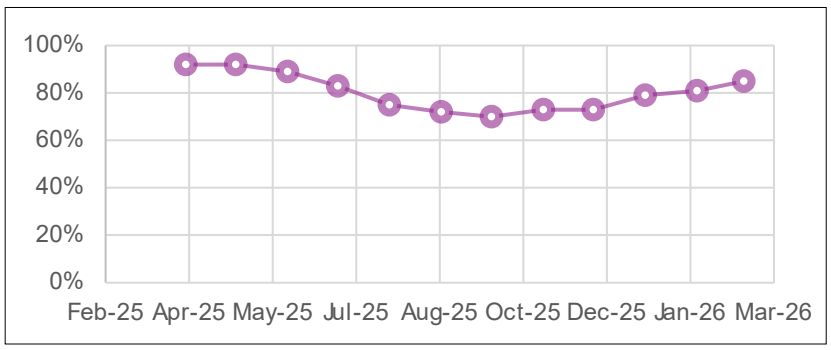
The supervision model continues to play a significant role in promoting professional curiosity, safe decision-making, emotional resilience, and consistent safeguarding practice across the organisation, while ensuring staff feel supported, challenged, and professionally empowered within their roles.

Uptake of supervision dipped in Q2 25-26 due to operational challenges and absence of safeguarding supervision trained staff, however mitigations were put in place to increase this through additional support for DSS cover. The provision of DSS continued to enable safe, supported practice while supervision compliance was increased.

One particular area impacted was the North East, which saw compliance rise from 44% in Q3 to 86% in Q4 with the introduction of Chloe Embling in the region as safeguarding specialist nurse. Chloe made supervision and reinstating safeguarding regional leadership in the North East a priority.

An area of focus for safeguarding supervision provision in the next financial year is the telemedicine division, where delivery is predominantly group sessions due to the volume of staff in this division. 39 group sessions were delivered across the Telemedicine division in 2025-26, and accessibility to 1:1 safeguarding supervision is limited.

Action:
Increase supervision provision for telemed division in 2026-27



Quality Assurance and Audit

Safeguarding Audits

Quarterly safeguarding audits are undertaken across the organisation, with each Regional Safeguarding Specialist Midwife/Nurse completing audits within their respective regions. This approach provides valuable insight into regional patient demographics, safeguarding themes, and emerging trends, whilst also strengthening relationships between safeguarding leads and frontline practitioners. Audit findings are shared through quarterly safeguarding meetings and are used to inform training, supervision, and quality improvement activity.

Audits are completed on a quarterly basis, enabling ongoing review of patient journeys, safeguarding outcomes, and practice standards. Sample sizes are determined proportionately, taking account of patient volumes, regional activity levels, and areas identified for further assurance. Key themes identified through audit activity during 2025-26 are outlined in the Safeguarding Audit Action Themes chart below.

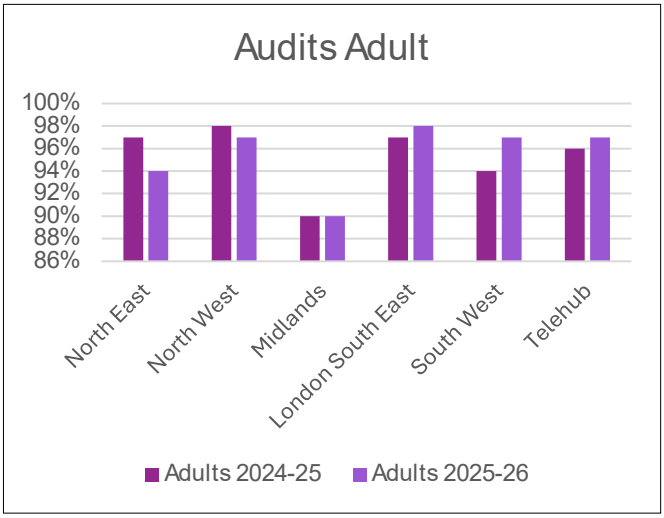
Overall, safeguarding audit scores have improved compared with the previous financial year, providing assurance regarding the continued development of safeguarding practice across services. This improvement is likely to reflect a combination of strengthened safeguarding oversight, enhanced supervision processes, and the successful implementation of the revised Level 3 safeguarding training programme. Audit findings have demonstrated improvements in safeguarding documentation, risk assessment, professional curiosity, and the rationale underpinning safeguarding decision making.

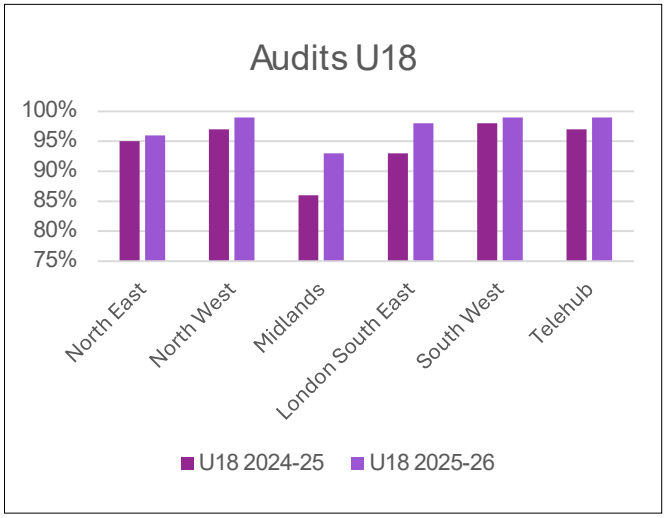
Safeguarding audits continue to play an important role in providing assurance regarding record keeping, safeguarding decision making, and adherence to organisational processes, while supporting the identification and embedding of learning and service improvements.

Although overall audit outcomes were positive, audit findings identified several recurring themes that informed quality improvement activity throughout the year.

The most frequently identified theme was missing or incomplete documentation, accounting for 69 audit findings. Whilst this did not necessarily indicate poor safeguarding practice, it highlighted opportunities to improve the recording of safeguarding discussions, rationale for decision making, and documentation of actions undertaken.

Importantly, no themes emerged regarding inappropriate closure of safeguarding concerns, incorrect referrals, trauma-informed practice, consent and information sharing, or consent documentation. This provides assurance that fundamental safeguarding principles continue to be applied consistently across services.





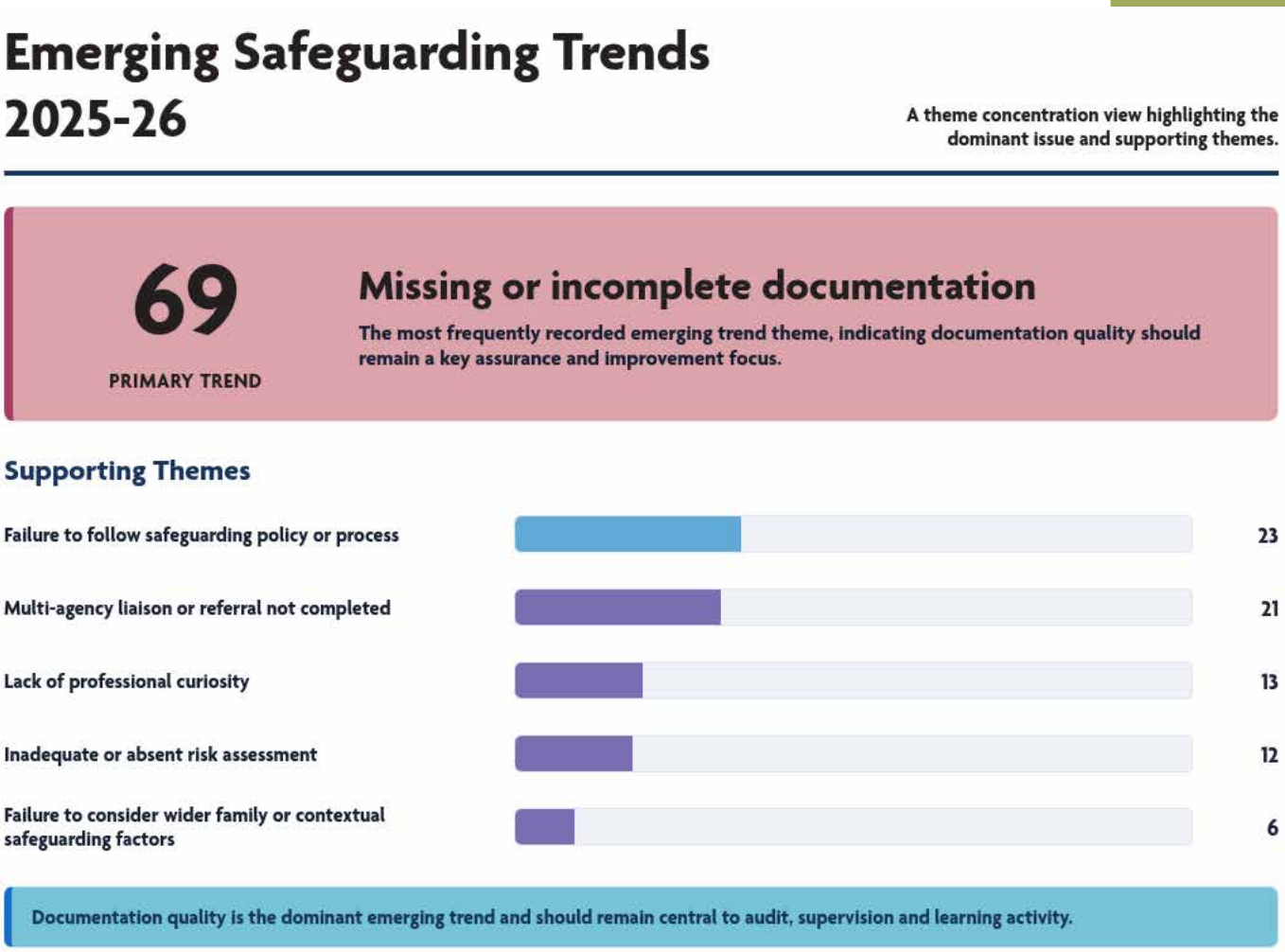
Emerging Trends

Audit findings suggest a shift away from concerns relating to safeguarding identification and towards opportunities to strengthen documentation quality and evidencing of professional judgement. This is a positive indicator of safeguarding maturity, demonstrating that staff are generally recognising and responding to safeguarding concerns appropriately, whilst ongoing development focuses on strengthening the recording and rationale underpinning decision making.

The relatively low number of findings relating to risk assessment and professional curiosity also suggests that staff are increasingly confident in identifying safeguarding vulnerabilities and undertaking appropriate safeguarding enquiries.

During 2025-26, a workstream was established to redesign the safeguarding audit tool, moving from a service-specific approach towards auditing the patient's entire journey through BPAS. This development aims to strengthen organisational oversight, provide greater insight into the patient experience, and support a more holistic assessment of safeguarding practice across care pathways. The revised audit tool is scheduled for implementation during Quarter 2 of 2026-27, and is being led on by Valencia Anderson.

Action:
Implement Phase 3 audit cycle reflecting patient journey as opposed to regional input



Learning from Incidents and Reviews

A total of 377 safeguarding-related incidents were reported across BPAS during 2025-26. The majority resulted in no physical harm to patients, providing assurance that staff are proactively identifying, reporting, and escalating safeguarding concerns, including near misses and process-related risks, before harm occurs.

The most frequently reported themes related to delays or omissions in safeguarding action, documentation quality, and multi-agency referral or follow-up processes. Analysis suggests safeguarding concerns are generally recognised appropriately, with incidents more commonly reflecting process, communication, and governance challenges rather than failures to identify safeguarding risk.

The largest theme related to delays or omissions in safeguarding action or escalation, accounting for approximately 63% of incidents. Learning identified through incident review highlighted opportunities to strengthen accountability, referral pathways, communication processes, and follow-up arrangements.

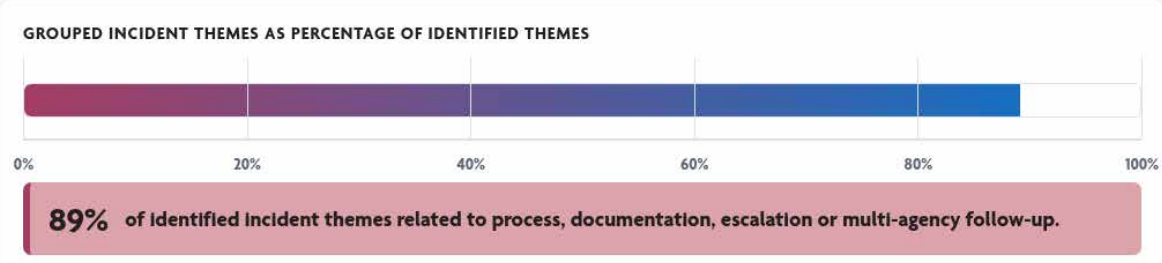
Learning from incidents has informed a number of improvements during 2025-26, including strengthened escalation pathways, clearer delineation of safeguarding responsibilities, enhanced documentation guidance, and review of referral and follow-up processes. These actions continue to support organisational learning, strengthen safeguarding governance, and reduce the risk of recurrence.

Action:

Share and embed learning from external safeguarding reviews

Key Safeguarding Incident Themes 2025-26

Most safeguarding incidents related to process, documentation and multi-agency follow-up rather than direct patient harm.



337

Process, documentation and follow-up themes

Includes escalation/action, record-keeping, compliance and multi-agency follow-up.

27

Direct patient incident theme

Safeguarding incident against patient whilst in contact with BPAS.

14

Notification / review themes

External safeguarding review and pregnant under 13 notification themes.

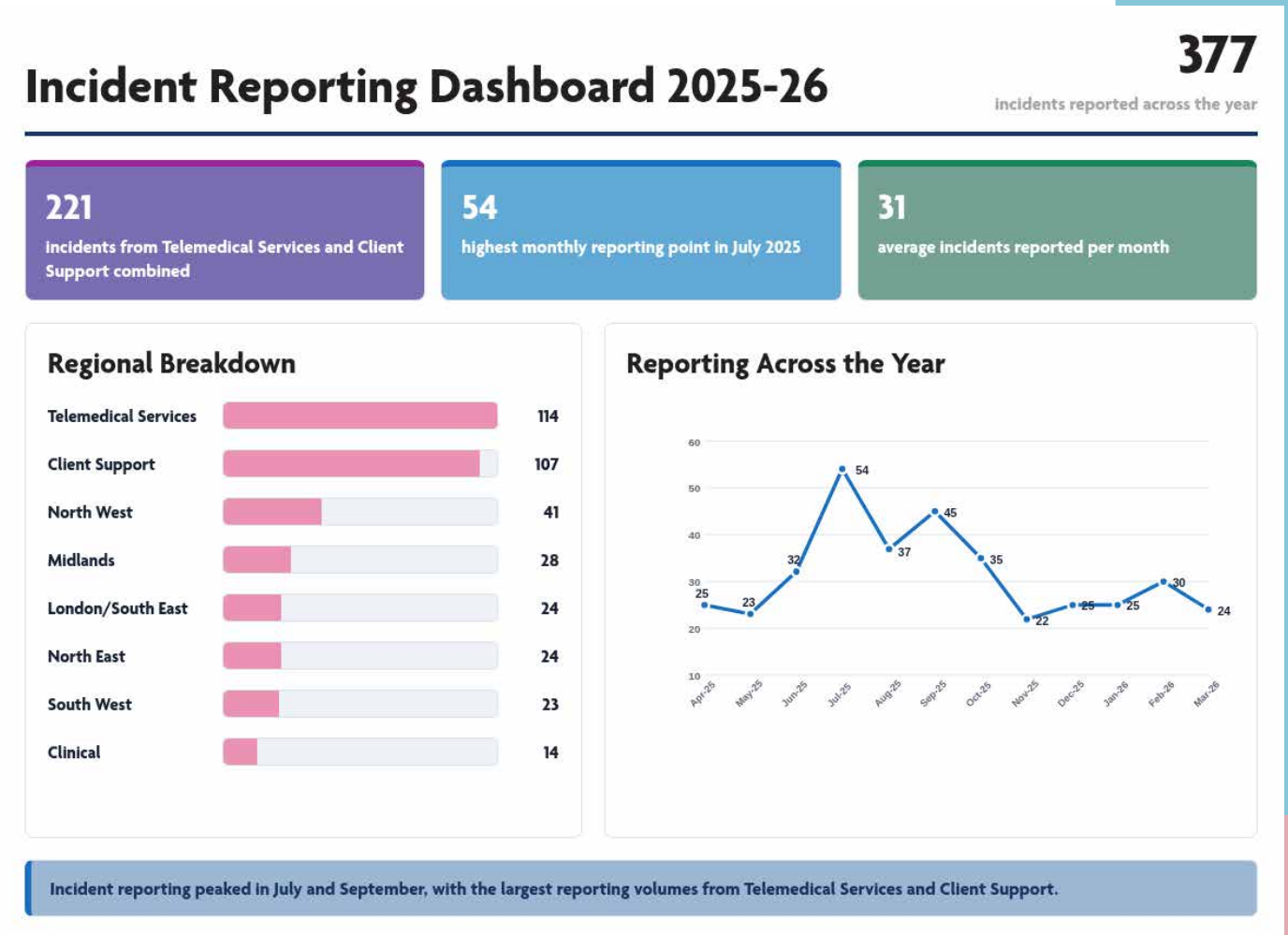
Regional Breakdown

Higher levels of safeguarding incident reporting within Telemedical Services and Client Support Services are likely to reflect greater patient contact volumes, earlier opportunities for safeguarding disclosure, the complexity of remote safeguarding assessment, and a well-established reporting culture within these services. This provides assurance that safeguarding concerns are being recognised, escalated, and reviewed appropriately within non-face-to-face care pathways.

Incident reporting peaked during July and September 2025, potentially reflecting periods of increased service demand, workforce pressures, enhanced safeguarding awareness, and increased governance and audit activity. Reporting remained consistent throughout the remainder of the year, demonstrating sustained staff engagement with safeguarding reporting processes.

Overall, incident data provides assurance of an embedded safeguarding culture across BPAS, with staff appropriately identifying and escalating concerns. The majority of incidents related to process, communication, and documentation rather than direct patient harm, indicating effective recognition of risk and opportunities for early intervention.

Learning from incident reviews has informed improvements to safeguarding governance, escalation pathways, role clarity, documentation standards, and multi-agency working processes. Priorities for 2026-27 include strengthening professional curiosity, improving the timeliness of safeguarding actions, enhancing documentation quality, reinforcing Level 3 clinician accountability, and continuing to embed learning from incidents, audits, and safeguarding reviews.



Policy and Procedure Development

Policies Reviewed 2025-26

During 2025-26, the safeguarding team continued to review and strengthen safeguarding policies and procedures to ensure alignment with legislative requirements, national guidance, and evolving service needs. Policies reviewed during the reporting period included the Safeguarding Adults at Risk of Harm Policy, Safeguarding Children and Young People Policy, CP-IS and FGM-IS guidance, and the FGM Standard Operating Procedure.

A significant safeguarding-related process change during the year was the removal of scripted follow-up pathways following EMA treatment. This change supported a more individualised, clinically led approach to follow-up care, enabling practitioners to use professional judgement and holistic assessment when determining the most appropriate follow-up arrangements for patients.

Further work was undertaken to strengthen organisational compliance with the Mental Capacity Act 2005, including updates to the mental capacity assessment sections within safeguarding policies and amendments to electronic medical record systems to ensure documentation, assessment processes, and clinical decision-making were aligned with current legislation and best practice guidance.

Pending 2026-27

Further policy development is planned for 2026-27, including a review of safeguarding support available to employees. This work aims to strengthen organisational responses to domestic abuse and improve support for line managers in recognising, responding to, and supporting employees who may be experiencing abuse or other safeguarding concerns.

These developments reflect BPAS's ongoing commitment to maintaining robust safeguarding governance arrangements and ensuring policies and procedures remain responsive to emerging risks, best practice, and the needs of patients and staff.

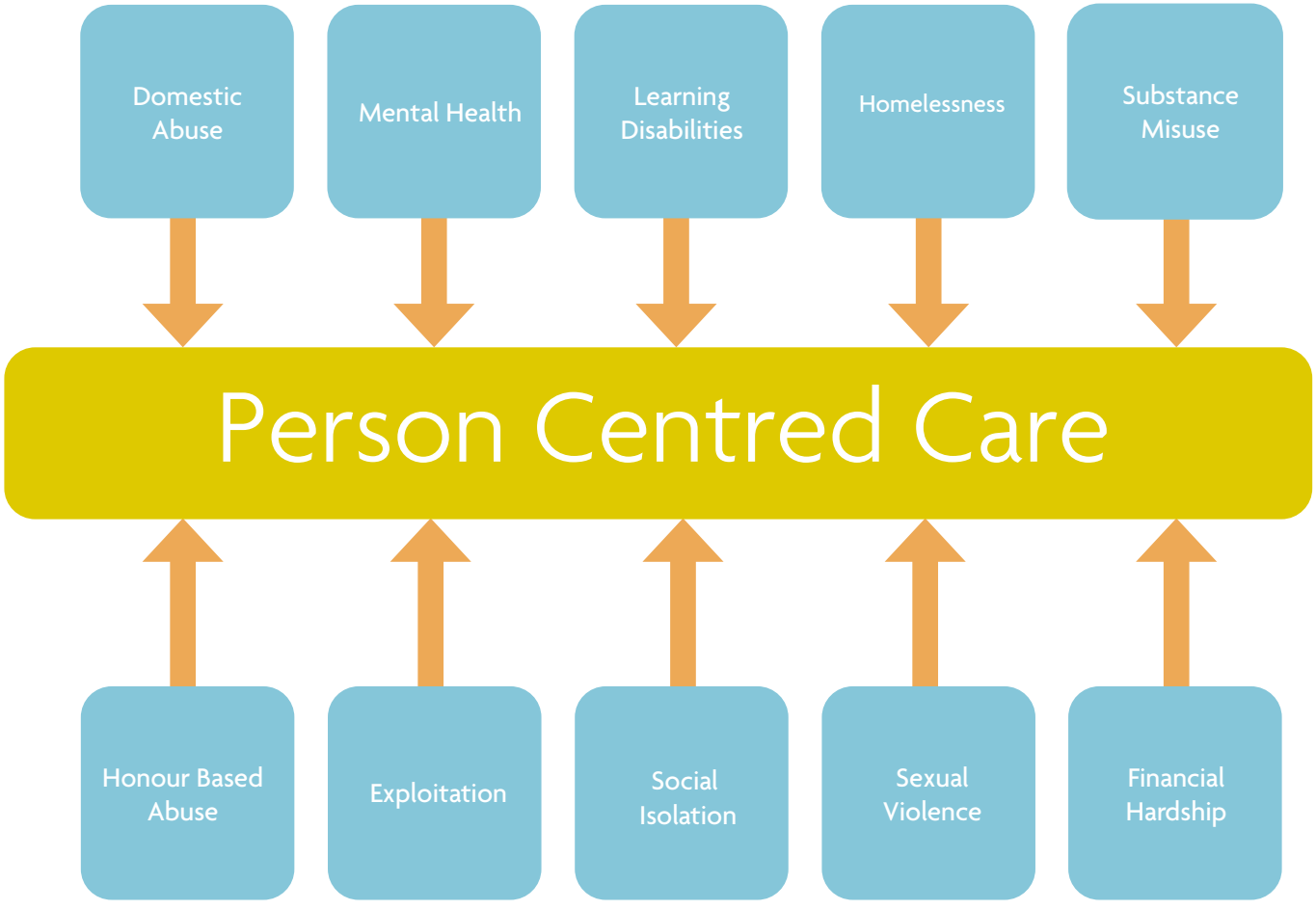
Equality, Diversity and Vulnerability

BPAS is committed to providing equitable, inclusive, and person-centred care, recognising that individual circumstances, protected characteristics, and wider social factors can influence both vulnerability and access to services.

Throughout 2025-26, safeguarding activity supported patients experiencing a range of vulnerabilities, including domestic abuse, sexual violence, exploitation, mental ill-health, learning disabilities, neurodiversity, substance misuse, homelessness, and social isolation. Safeguarding assessments were undertaken with consideration of each individual's unique circumstances, recognising that vulnerability is often shaped by multiple interacting factors.

The safeguarding team continued to promote trauma-informed and anti-discriminatory practice through policy development, training, supervision, and case discussions. Staff were supported to consider communication needs, disability, cultural factors, mental capacity, and the impact of coercion or control when assessing risk and planning care.

Through collaborative working with statutory and voluntary sector partners, patients were supported to access specialist services where additional needs were identified. This approach helps ensure safeguarding practice remains inclusive, proportionate, and responsive to the diverse needs of patients accessing BPAS services.



Key Risks and Areas for Development

Overall, safeguarding arrangements across BPAS remain effective and provide strong assurance regarding the identification, assessment, and management of safeguarding concerns. However, several areas have been identified for continued focus during 2026-27 to support service resilience, quality improvement, and the ongoing development of safeguarding practice.

Key themes include strengthening safeguarding supervision provision within Telemedicine services, responding to the increasing complexity of adult safeguarding presentations, improving documentation quality and evidencing of professional judgement, maintaining workforce resilience, embedding newly implemented safeguarding processes, and continuing to strengthen partnership working across multiple safeguarding systems.

These areas do not represent significant concerns regarding current safeguarding practice, but reflect opportunities to further enhance safeguarding effectiveness, consistency, and organisational assurance.

Safeguarding Risk Focus 2026-27

A visual summary of the key risk areas, current assurance position and planned focus for the year ahead.

Telemedicine Supervision

CURRENT POSITION
Group supervision model

FOCUS 2026-27
Increase access to 1:1 supervision

Adult Safeguarding Complexity

CURRENT POSITION
Increasing complexity

FOCUS 2026-27
Continue workforce development

Documentation Quality

CURRENT POSITION
Improving but remains theme

FOCUS 2026-27
Audit and supervision focus

Workforce Resilience

CURRENT POSITION
Stable with mitigations

FOCUS 2026-27
Succession planning

SGRA Implementation

CURRENT POSITION
Pilot phase

FOCUS 2026-27
Organisation-wide rollout

Partnership Variability

CURRENT POSITION
National challenge

FOCUS 2026-27
Strengthen local engagement

Supervision
Move from group capacity toward targeted 1:1 access.

Assurance
Use audit, documentation review and supervision to improve quality.

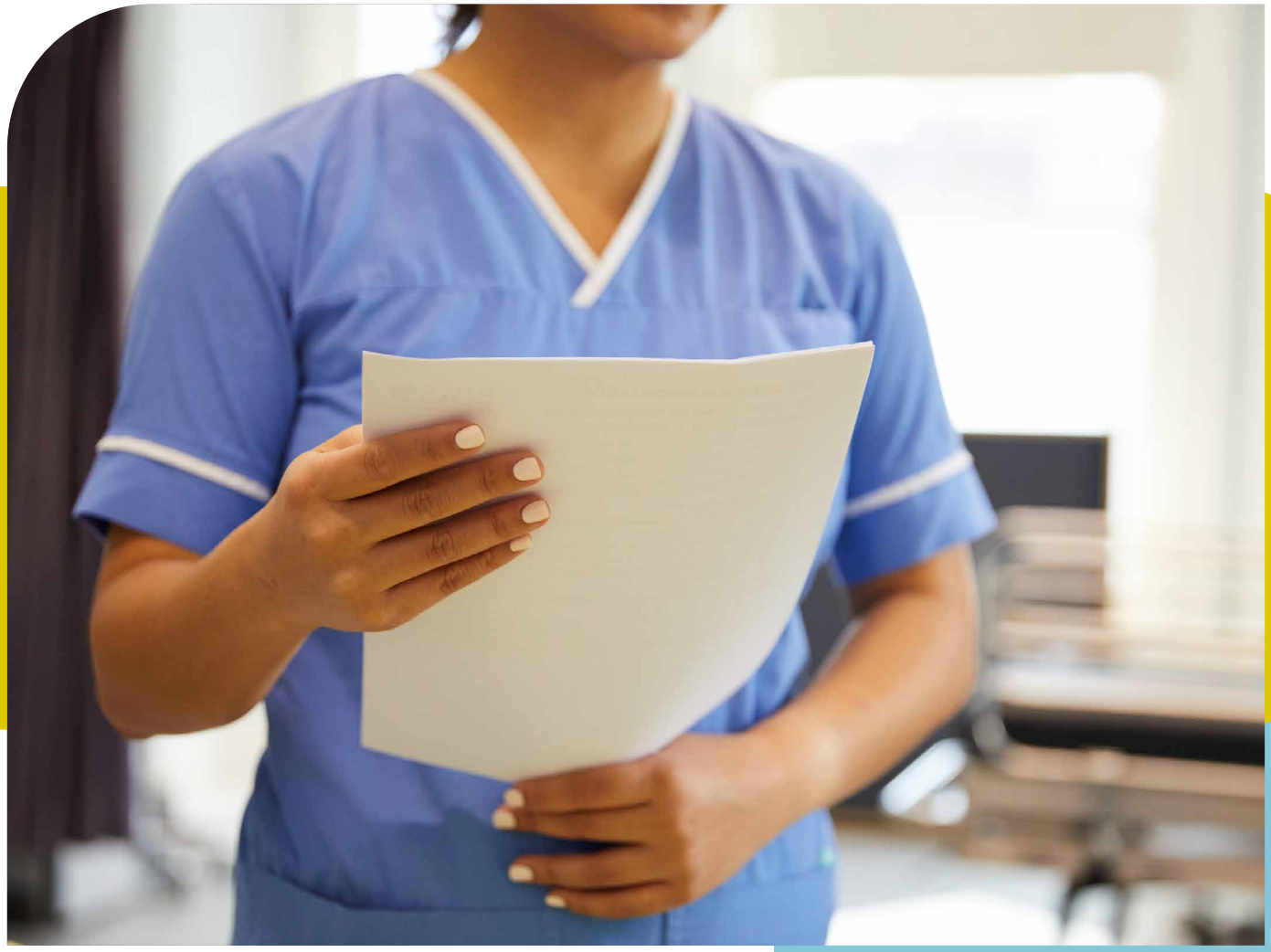
Sustainability
Protect workforce resilience through succession planning and engagement.

Priorities for the Coming Year

Looking ahead to the next 12 months, we are committed to strengthening our safeguarding culture. Our key priorities are shown in the table below:

Table: Actions Identified 2025-26

No.	Actions from 2025-26
1.	360 feedback for DSS support service to identify areas of improvement and development
2.	Implement revised SGRA - pilot evaluation, organisation-wide impementation, audit impact
3.	Audit impact of CP-IS checking
4.	Develop in house domestic abuse training to replace eLFH level 1 and level 2
5.	Develop standalone trauma-informed training package
6.	Share and embed learning from external safeguarding reviews
7.	Increase supervision provision for telemed division 2026-27
8.	Implement Phase 3 audit cycle reflecting patient journey as opposed to regional input



Conclusion and Assurance Statement

This report highlights both the scale and complexity of safeguarding throughout 2025-26, BPAS has continued to demonstrate a strong commitment to safeguarding patients through robust governance arrangements, effective risk management processes, workforce development, and collaborative multi-agency working. Safeguarding remains embedded throughout the organisation and is recognised as a fundamental component of delivering safe, compassionate, and person-centred abortion care.

This report highlights both the scale and complexity of safeguarding activity across BPAS. The completion of over 15,500 safeguarding risk assessments, management of more than 9,000 safeguarding referrals, increasing utilisation of specialist safeguarding support, and continued high levels of safeguarding disclosure within the Booking and Information Centre demonstrate an organisation that remains vigilant in identifying and responding to vulnerability.

Significant progress has been achieved during the reporting period through the implementation of the enhanced Level 3 Safeguarding Training programme, strengthening of safeguarding support within BIC, improvements to safeguarding governance and escalation pathways, continued development of safeguarding supervision, and implementation of learning identified through audits, incidents, and reviews. These developments have contributed to increased workforce confidence, stronger professional curiosity, improved safeguarding decision making, and greater consistency in practice across services.

Whilst safeguarding arrangements remain effective, the organisation recognises the need to continue evolving in response to emerging risks, increasing complexity within adult safeguarding, changing patient needs, and the ongoing development of telemedical services. Priorities identified for 2026-27 will support further strengthening of safeguarding supervision, trauma-informed practice, domestic abuse competency, workforce resilience, documentation standards, and patient journey assurance.

Overall, the evidence presented within this report provides assurance that safeguarding arrangements across BPAS are effective, responsive, and embedded within organisational culture. Patients continue to benefit from access to specialist safeguarding expertise, robust governance processes, and a workforce committed to delivering safe, equitable, and high-quality care. BPAS remains committed to continuous improvement and to ensuring safeguarding remains at the heart of service delivery across all areas of the organisation.

Appendix 1 - Progress and Actions 2024-25

No.	Actions Identified 2024-25	Progress	Comment
1	Recruitment and onboarding of an additional safeguarding role within the BIC.	Complete	None
2	Further strengthen safeguarding audits through the development and implementation of a national, patient-centred audit, ensuring consistent standards, improved service user experience, and continuous quality improvement.	Ongoing	Patient journey' audits planned, delayed due to operational pressures however planned for launch Q2 26-27
3	Implement safeguarding audits for the Support Services Division (Booking and Information Centres, counselling and Aftercare department).	Complete	None
4	The safeguarding risk assessment to be reviewed within the electronic medical record to improve understanding reporting of themes and outcomes of safeguarding referrals.	Ongoing with PILOT planned June 2026	SGRA has been reviewed and PILOT planned
5	The DASH risk assessment to be built into the electronic medical record to enable reporting of themes and outcomes of MARAC referrals.	Ongoing pending EMR system changes	Plan for this to be incorporated to new SGRA as per PILOT above
6	Author and launch new policy regarding safeguarding concerns involving staff. This will be authored in collaboration with human resources colleagues.	Escalated	Awaiting support from HR
7	Review the level 3 safeguarding packages and to deliver them with a face-to-face, onsite training.	Complete	None
8	Perinatal mental health training module to be delivered as an additional 'building block' of safeguarding training.	Complete	None
9	Continue to analyse incident trends and work on further reducing the number of moderate and low harm cases.	Complete	None
10	Breaking down the delay or omission of safeguarding process, action, intervention, or referral' category to identify causes, address recurring themes, and implement more precise improvements in safeguarding practice.	Complete	None
11	Review the safeguarding risk assessments, guides and scripts to ensure patients are informed sensitively and clearly when referrals are required.	Complete	None
12	Review scripts for discussion of support persons at appointments.	Complete	None
13	Proposal for a fast-track referral process for high-risk cases, removing the need for standard forms to improve efficiency and response times.	Complete	Launch of complex care team (CCT) PILOT in April 2026
Continued from 2023-24			
No.	Actions from 2024-25	Progress	Comment
14	Face to face safeguarding training packages to be put in place	Complete	None
15	Creation of specific perinatal mental health training packages to support staff and to align with the mental health crisis SOP	Complete	None
16	Review the patient electronic medicalrecords and safeguarding risk assessment for adults at risk	Ongoing	New SGRA PILOT to launch June 2026
17	A safeguarding strategy for BPAS to be developed to ensure the safeguarding journey at BPAS is cinsistent and clear to staff at every 'safety netting' opportunity follolwing an extended period of system change	Complete	None
18	To consider system changes to mandate safeguarding risk assessments for all patients	Ongoing	In progress, system changes delayed due to pending new electronic medical record system

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PRI-DEC-150

July 2026